DRVD
CONFIDENTIAL REPORT

AN INVESTIGATION INTO THE DEATH OF GH

Thirty-two year-old, Caucasian female patient at Central State Hospital, found dead in four-point restraints.

DRVD CASE# 96-0102 M
Department For Rights of Virginians With Disabilities
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I. Introduction:

This is a summary of the findings of the investigation by the Department for Rights of Virginians with Disabilities (DRVD) into the death of GH, a 32 year-old female patient at Central State Hospital (CSH). On June 29, 1996, GH was found dead in a seclusion and restraint room on the Forensic Unit, where she had been placed in four-point restraints to the bed.

DRVD conducted this investigation pursuant to the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10801 et seq.). The investigation included a review of the following documents and records:

- The Medical Examiner's report and autopsy of GHCSH hospital records regarding GH
- Medical records from the Medical College of Virginia (MCV), Southside Regional Medical Center (SRMC), and Hiram Davis Medical Center (HDMC) regarding GH
- Prior investigations of abuse and neglect complaints by GH
- MANDT guidelines and training manual
- CSH and Forensic Unit policies
- A memorandum by GH's prior treating psychiatrist at CSH
- Attendance and training records of staff assigned to the Forensic Unit
- Local Human Rights Committee (LHRC) minutes regarding GH

The investigation included interviews of the following individuals:

- GH's treating psychiatrist, Building 39,Ward 7, head of treatment team
- Prior treating psychiatrist, Building 96
- Clinical Nurse Specialist, Individual Therapist, member of treatment team
- Unit Social Worker, member of treatment team
- Ward Nurse and Forensic Mental Health Technicians (FMHTs) on duty at time of GH's death
- Practical nursing staff and FMHTs, Forensic Unit
- Charge Nurse, Building 39
- Registered nursing staff, Forensic Unit and Building 96
- Human Services Care Coordinators (HSCSs), Forensic Unit
- Forensic Unit Nursing Supervisor
- Former Forensic Unit Director
- Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) CSH Facility Advocates
- State Police Investigator
- Other Patients on the Forensic Unit
- Forensic Unit Psychologist
- CSH Chief Psychologist
- CSH Medical Director
- Forensic Unit Primary Care Physician

The investigation also included a review of the clinical records by a board certified psychiatrist under contract to DRVD as a medical expert.

II. Background

A. The Facility

CSH is a 495 bed state psychiatric facility operated by DMHMRSAS located in Dinwiddie County. The hospital includes a maximum-security forensic unit in Building 39, an adolescent unit, and a civil psychiatric hospital. The Forensic Unit had seven operating wards in June of 1996, only one of which served female patients. The Forensic Unit has its own Director, Medical Director, and Director of Nursing Services and its own security force. Patient care is planned and delivered by a treatment team composed of a psychiatrist, a psychologist, a social worker, a primary therapist, and possibly a

nurse or forensic mental health technician (FMHT). According to the Forensic Director, the acceptable minimum staffing is one nurse and four FMHTs per ward.

CSH is accredited by the Joint Commission on Accreditation of Health Organizations (JCAHO). JCAHO conducted an on-site review of CSH on June 24-27, 1996, two days before the death of GH. Following notification of this "critical incident," JCAHO completed an additional review in March 1997. CSH was placed on conditional accreditation status following a site review in August 1997, and restored to full status on May 4, 1998. Between April 28 and May 2, 1997, the United States Department of Justice conducted an on-site investigation of CSH under the Civil Rights of Institutionalized Persons Act (CRIPA), and negotiations regarding a corrective action plan are on-going.

B. The Patient

GH was a 32 year-old female Caucasian resident at Central State Hospital. GH had a history of nearly continuous psychiatric hospitalizations beginning at age 14, including 5 prior admissions to CSH. From 1989 to 1991 she was a resident at CSH following transfer from Marlboro Hospital in Massachusetts where she had been hospitalized from 1984 to 1989. On June 11, 1992, GH was admitted to CSH upon transfer from John Umstead Hospital in North Carolina in order to be closer to her mother, a Richmond, Virginia resident. Her admission diagnosis was Atypical Psychosis, Polysubstance Abuse, Adjustment Disorder with Depressed Mood, Mild Mental Retardation, and Atypical Personality Disorder. She was also diagnosed as having pseudo-seizures and as HIV positive.

Primary medical care for GH was provided by physicians employed by CSH. Emergency and specialty care was provided through Southside Regional Medical Center (SRMC), the Medical College of Virginia (MCV), and Hiram Davis Medical Center (HDMC). An annotated listing of consultations and examinations is set forth at Appendix A.

III. Circumstances Surrounding the Incident

A. Summary of Treatment in Building 96

June 1992 to August 1995

GH resided at Central State Hospital, Building 96, from June 11, 1992 until August 10, 1995. During this time, she received medical treatment on several occasions for rashes and self-inflicted injuries (swallowing safety pins and glass). Her medical records also contain numerous complaints of shortness of breath and treatment for asthma, and of seizures or "pseudoseizures."

A physical examination on June 12, 1992, noted first degree atrial ventricular block, seizure disorder, and asthma. On July 1, 1993, GH was examined at HDMC for complaints of pain and tingling in her hands, arms, and chest, particularly after a seizure. The record notes "sternal area chest pain- 'daily'- associated with nausea. R/O GI disease. R/O cardiac origin." There is no cardiac follow-up noted in the CSH record. She was placed on a trial of Dilantin in December 1993, but the CSH medical record contains no diagnosis of seizure disorder and no description of clinical observations regarding her seizures.

On December 2, 1993, the MCV Infectious Disease Clinic noted that GH had pulmonary hypertension. In February of 1994, she complained of difficulty in breathing and was given a prednisone taper. On February 24 and March 17, 1994, the MCV Pulmonary Clinic reported possible pulmonary hypertension, but the CSH record contained neither a referral form nor a report regarding either of these visits. On April 25, 1994, she was reportedly "falling on the ward" and was transferred to SRMC; however, her record at SRMC indicated only treatment for self-injurious behaviors (swallowing glass and plastic). It was noted again in November 1994 that she continued to exhibit "seizures or pseudo-seizures."

On March 25, 1995, SRMC noted possible cardio-vascular and pulmonary peculiarities, but again the CSH record contained no report of that visit. Chest X-rays at HDMC on March 30 and April 18, 1995, were read as "normal cardiomediastinal silhouette" and "heart size is

normal and unchanged and there is no abnormality of the great vessels." Theodur, Brethine, and Azmacort and Ventolin inhalers were used to address her respiratory complaints. No further evaluation of a possible cardiac origin was evidenced in GH's clinical record at CSH. On July 13, 1995, GH was found lying on the floor of the ward with "flaccid unconsciousness" and an abnormal EKG was reported by SRMC. On July 31, 1995, she was found lying on the floor and her record noted that "[s]he felt dizzy and everything blacked out." A presumptive diagnosis of epileptic process was made by her treating psychiatrist.

GH showed sporadic improvement in her ability to control her impulses during her treatment in Building 96. She earned grounds privileges, was allowed to visit her mother in the community, and was actively involved in discharge planning. At other times, her self-abusive behaviors prompted her return to prolonged one-to-one (1:1) observation and the frequent use of seclusion and restraints. Building 96 staff described GH as one of the most difficult patients with whom they had ever dealt.

The CSH Treatment Plan Update and Retention Note for November 7, 1994 reported that GH "[h]as shown a significant decrease in aggressive & assaultive behavior. Has not been self-mutilative in the recent past." On January 17,1995, the treating psychiatrist noted rages which continued for one to three days and included homicidal and suicidal threats. A February 6, 1995 Update Note stated that GH "[h]as demonstrated a recent ↓ in aggressive/assaultive episodes." On May 1, 1995, the treatment team reported that GH "has intermittent episodes of agitated and aggressive behavior", and noted on June 6, 1995 that "[t]here is no significant change in the patient's mental status or behavior. Intermittently, she is loud, abusive, and disruptive though major management issues are not frequent."

Psychoactive medication management was characterized by trials of the following: Tegretol and/or Dilantin, Prozac or Doxepin, Lithium Carbonate or Depakote, Haldol, Ativan, Prolixin, Thorazine, Stelazine, Vistaril, and Mallaril.

On July 5, 1995, GH was upset and verbally abusive towards staff. She pulled the handle off of a metal food cart and hit one staff

member. She then struck the window of a hallway door with the metal handle, and flying glass injured the eye of another staff member. GH was subsequently placed in seclusion. Following this incident, transfer to the forensic unit was discussed, but did not occur. The chart indicates that the treatment team planned to pursue further evaluation of possible organic brain abnormality or brain chemistry as a significant cause of GH's behaviors, to pursue relaxation therapy, and to develop a behavioral plan which would provide clearer consequences for aggressive or self-injurious behaviors.

In a July 11, 1995 memorandum to the CSH Hospital Director, the treating psychiatrist in Building 96 documented his concerns regarding GH's treatment and safety. He believed that GH had a seizure disorder, that perfect medication trials had yet to be accomplished, and he recommended a Positron Emission Tomography (PET) scan and further investigation of brain function. He argued for a comprehensive, humanistic approach to treatment, stating that:

> Restrictive approaches to the management of this patient increased her maladaptive outbursts and led to more dangerous incidents. Therefore, in the past 6-9 months, we attempted to give her as many freedoms and privileges as possible, and the patient showed commensurate improvement…a restrictive approach will be viewed as punitive by this patient who has experienced alienation and trauma from others through most of her life. This type of treatment is likely to deepen her wounds and confirm her in her social alienation.

At the end of the memo, he warned that:

> While staff members may fear the patient, it is far more likely that with increasing disciplinary pressures, the patient, as evidenced by the events of the past, may commit suicide. Staff members should… always remember that following a physical struggle and emotional strain, a patient may die in restraints and in front of the observing eyes of the custodians. This is rendered more

likely in this patient by her propensity to seizures and asthma, both of which have in the past been induced by emotional stress.

B. Summary of Treatment in the Forensic Unit

August 1995 to March 1996

As a result of the July 5, 1995 assault on CSH staff, criminal charges were filed against GH. On August 10, 1995, GH was abusive and threatening toward staff after returning from her court hearing, and the forensic crisis response team was called to restrain her. GH was placed in four-point restraints and administratively transferred to the Forensic Unit in Building 39. The CSH medical record contained no signed physician's order either for the transfer or for her seclusion and restraint on August 10, 1995. The chart does not indicate who made the decision to transfer GH, and a transfer summary was not prepared by either the Building 96 treating psychiatrist or any other staff member. Forensic Unit staff confirmed that there was no discussion with members of the Building 96 treatment team regarding the transfer of GH or her treatment.

The Forensic Unit initially followed the treatment plan from the Building 96 treatment team. The diagnosis was "Schizoaffective Disorder, Personality Disorder (NOS), HIV+, Bronchial Asthma, Pseudo-seizures." The problems to be addressed were "Hx of agitated, aggressive, assaultive, and self-mutilating behavior; HIV+; asthma; and pseudo-seizures."

On August 31, 1995, the MCV Infectious Disease Clinic noted an abnormal chest x-ray and reported "a large pulmonary artery consistent with possible pulmonary arterial hypertension or conceivably a left to right shunt." These findings were not commented upon in the CSH record and no follow-up treatment regarding this diagnosis was reflected in the record.

On October 29, 1995, GH was referred to the SRMC emergency room for "persistent complaint of chest pain and ? syncope." A review of the x-ray revealed:

> The heart size is normal. There is prominence of both hila, as well as main pulmonary artery segment. Slight interstitial prominence is present throughout both lungs....Questionable early infiltrate, right lung base. Prominent hila and main pulmonary artery segment. Question pulmonary arterial hypertension. ? Does patient have sarcoidosis. Computed tomography could be performed for complete evaluation of the hilar regions to exclude adenopathy.

The CSH medical record contained no copy of the SRMC radiology report or any other records from SRMC regarding this visit. The CSH physician's progress notes for October 29, 1995, noted findings of asthma exacerbation or bronchitis and Bactrim was prescribed.

On November 8, 1995, the treatment team deleted pseudo-seizures as a separate medical problem and noted that they would be addressed in the general treatment of GH's agitated, aggressive, assaultive, and self-mutilating behaviors.

On November 13, 1995, the Institute of Law, Psychiatry and Public Policy (ILPPP) in Charlottesville, Virginia, completed a competency evaluation of GH. The evaluation noted the organic nature of GH's psychiatric illness and emphasized her severe developmental deficits, both organic and psychological. The ILPPP offered a theoretical framework for treatment:

> (Her) condition is characterized by labile mood and discrete episodes of failure to resist aggressive impulses that result in serious assaultive acts or destruction of property. Furthermore, the degree of aggressiveness expressed during the episodes is grossly out of proportion to any provocation or precipitating psychosocial stressor. (GH) has been noted to have episodes of uncontrollable rage, disinhibition, and aggressive behavior as early as second grade. After these outbursts, she was noted to fall asleep and afterwards seemed as if she were a "different person"...(GH) most likely is suffering

> from a brain abnormality which manifests as seizures and atonic episodes and which contribute to her emotional and behavioral outbursts..(GH) has had a Compound Tomography Scan of the brain as well as an EEG of the brain. Neither of these have shown any abnormality to our knowledge. However, it is not necessary that one have a specific structural abnormality or even an EEG abnormality to be diagnosed with a seizure disorder. (GH) has not had the opportunity to be given state-of-the-art tests which might be more sensitive to picking up brain abnormalities. For example, she has not had a Magnetic Resonance Imaging (MRI) Scan of the brain, nor has she had prolonged EEG's with video monitoring, nor has she had EEG's with nasopharyngeal leads. These latter two tests would be given to persons who's (sic) seizure focus in an area of the brain which would not be accessible to more routine EEG's. In such persons, routine EEG's would frequently be normal.

The ILPPP interviewed the prior treating psychiatrist from Building 96 and noted that the treatment environment at CSH was possibly compromised:

> Dr. (omitted) acknowledged that the staff at Central State Hospital are known to "provoke and harass various patients." Furthermore, he stated that…there was great animosity from the staff towards (GH). He stated, "they want to see her fail and that many staff would do anything to make her fail." These are his personal observations as well as observations of some other staff with whom he has spoken concerning the subject.

The ILPPP evaluation concluded that:

> In the majority of cases we believe that one should offer a clinical diagnosis as part of the evaluation.

> This case is one in which we feel that offering descriptive information and not assigning a particular diagnosis would be preferable. Ms. H's clinical picture is extremely complex, and the clinical record is very much at variance with itself and in places quite wanting. To offer a definitive diagnosis with the available information might be misleading.

On February 7, 1996, GH's Treatment Plan Update said "Pt has exhibited very little evidence of aggressive or self-mutilative behavior. However, behavior is attention seeking and manipulative." The nursing notes in the CSH record describe episodes related to "falling out" or dizziness. On March 12, 1996, GH reported feeling dizzy and complained of chest discomfort. On March 13, 1996, "seizure activity" was noted. On March 14, 1996, GH complained of shortness of breath and "fell on the floor."

A Temporary Custody Evaluation filed on March 18, 1996, indicated that GH's diagnosis of Schizoaffective Disorder was not confirmed or supported by the testing:

> (GH) carries a diagnosis of Schizoaffective Disorder, Personality Disorder NOS (with antisocial and borderline features). Schizoaffective Disorder is a major mental illness characterized by severe disturbance in thinking and mood. People with this disorder experience symptoms of schizophrenia (such as disorganized thinking, auditory hallucinations, or delusion) as well as mood disturbance (episodes of severe depression or elevation in mood). However, (GH's) reports of auditory hallucinations are unreliable. Previous psychological testing has not found psychotic processes. The mood disturbance, acting out behavior, poor frustration tolerance, intermittent auditory hallucinations when agitated, and poor impulse control could be accounted for by her severe disturbance in personality functioning. A diagnosis of Borderline Personality

> is consistent with these phenomenon and behaviors as well as (GH's) lack of integrated self-concept and stormy interpersonal relationships.

The ILPPP Competency Evaluation and the Temporary Custody Evaluation were maintained in a separate file, designated as the "legal section" of the CSH patient record, located in a separate building and not a part of the clinical chart. There is no documentation that the treatment team reviewed or considered these reports in treatment planning. GH's treating psychiatrist advised that she had read the ILPPP report; however, the Forensic Unit primary care physician stated that he never saw the recommendations from the ILPPP regarding further evaluation because they were not part of the clinical record. He was also unaware of any prior recommendations for more extensive neurological testing and had never seen the July 11, 1995 memo by the Building 96 treating psychiatrist.

The clinical notes and staff interviews reflect that in March 1996 there was an increase in aggressive behaviors toward staff and other residents, as well as in self-injurious behaviors. Assaultive behaviors related to her HIV status were particularly difficult for staff to manage. GH threatened to infect staff and other residents with HIV, and would bite the inside of her mouth, her lips, and her arms, spitting bloody saliva on others or into their food. The notes and staff identified several possible "triggers" for these escalating behaviors. The more restrictive forensic setting prevented visits home to see her mother, and her mother's health problems precluded visitation at CSH. GH's concerns about her father's terminal illness were well-documented, and she had lost her step-father in February 1996.

GH also continued to experience episodes of shortness of breath and "pseudo-seizures", which were generally regarded by staff as manipulative behaviors. During these episodes she would fall to the floor and state that she was unable to move.

On March 29, 1996, GH was transported to SRMC for "evaluation of exacerbation of respiratory status." The doctor's notes report wheezes and sternal pain. A radiograph of the chest indicated that the pulmonary artery was prominent and was suspicious for a congenital heart defect such as an "atrial septal defect with superimposed

pulmonary arterial hypertension." The CSH chart does not address the SRMC findings.

During her stay in the Forensic Unit, GH generally participated in individual therapy for 30 minutes approximately twice a week. She was also involved in several groups, which included Current Events, Symptom Management, Women's Issues, and Health Teaching. Participation in an anger management group was requested by the treatment team but was never made available to GH. The primary therapy notes consistently reflect that GH sought participation in group activities and that her behavior was generally appropriate in these groups.

C. Implementation of the Individual Behavior Plan

April 1996 to May 1996

Forensic Unit staff reported that by April 1996 they were frustrated and frightened by their inability to safely manage GH's behaviors. Patients also expressed fear for their safety and circulated a petition requesting that GH be removed from Ward 7.

On April 4, 1996, the treatment team re-stated GH's primary problem area as agitated, aggressive, assaultive, and self-mutilating behavior and began development of an Individual Behavior Plan (IBP) which would target these behaviors. The team reviewed prior IBPs, one of which called for "four-point restraints to bed for a **minimum of 10 hours** with the **last hour** reflecting appropriate behavior." (Emphasis added). The team recorded that GH had been:

> involved in Treatment Plans which have utilized a **minimum of 12 hours** of restraints and seclusion. These treatment plans were able to significantly modify her behavior over a two to three month period of time depending on the frequency and intensity of behavior. (Emphasis added).

The team also developed a baseline which showed that the average time required for GH to calm down was 6.8 hours.

The treatment team developed an IBP which utilized the extensive use of seclusion and restraint to address "assaultive behaviors" and "self-mutilative/suicidal gestures". The IBP called for **a minimum of 48 hours** in 5-point restraint to bed. If GH demonstrated calm and cooperative behavior during **the last 8 hours**, she would then be placed in 4-point walking restraints for a **minimum of 4 hours**. GH would then move to wrist restraints for a **minimum of 4 hours**, after which she would be released from restraints. If she "became agitated" at any time during this gradual release process, she would be returned to 5-point restraint to bed. After 8 hours of acceptable behavior, the gradual release process would be repeated.

The IBP noted that, while GH was in restraints,

> verbal interaction should be kept to a minimum. Her requests should be noted and passed on to the nurse or other appropriate staff. She should not be spoken to except to give simple instructions. **By no means should staff engage in "small talk" with the patient or participate in arguments. These interactions may have the unwanted effect of reinforcing the time in restraints for the patient.**
>
> (Emphasis in original).

The IBP also awarded points for positive behavior which could be used to purchase items such as candy or cigarettes.

The CSH Chief Psychologist and the Forensic Unit Psychologist were interviewed by DRVD concerning the development of the IBP. Neither could identify any professional literature, peer review materials, or clinical studies upon which they relied in developing GH's IBP. Both stated that the selection of a minimum of 48 hours in five-point restraints was not based on any recognized guidelines regarding the appropriate length of seclusion and restraint in behavioral management plans. Neither could provide a rationale for the increase from "at least 10 hours" in restraints in the earlier IBP to "48 hours minimum" in restraints in the last IBP.

The Forensic Unit Psychologist stated that less restrictive options were considered, such as 2:1 observation either in the back of the ward or in a vacant ward, but that treatment options were limited by the lack of staff and available space in the facility. The Forensic Unit Psychologist stated that additional medication options were also discussed with the treating staff psychiatrist but were ruled out. Treatment team members all agreed that GH initially wanted a behavior plan in order to earn credits for cigarettes.

The Individual Behavior Plan was signed by GH and the members of the treatment team on April 15, 1996. The plan received the interim approval of a sub-committee of the Local Human Rights Committee and was implemented on April 29, 1996. On June 5, 1996, the primary therapist filed a report with the LHRC regarding implementation of the IBP from April 29 to May 31, 1996. In the thirty-three days covered by this report, there had been two aggressive acts, five threats to harm others, thirteen infection risk behaviors, six behaviors harmful to self, and two threats to harm self. Behavior was scored as compliant for 49% of the time. It was reported that GH spent 257 hours in seclusion and restraint during this period. The report stated that:

> The total incidents of assaultive and self-mutilating behavior reflect the behavior of Ms H while in seclusion/restraint. She was able to slip out of her wrist restraints and to continue to do harm to herself. This occurred less frequently when she was on 1:1 staff supervision (eye contact rather than arm's length). **For this reason, the plan is being modified to include 1:1 eye contact supervision whenever Ms. H is in restraints. Arm's length 1:1 would place the staff at-risk of injury and would give Ms. H more attention than deemed therapeutic.**
>
> (Emphasis in original)

The report recommended that the IBP be continued for another month "[i]n spite of the frequent episodes of violent behavior directed at self or others, and the extensive number of hours Ms. H spent in S/R…."

A revised IBP was presented to the Local Human Rights Committee and approved on June 7, 1996, with an amendment which required 1:1 supervision of GH while she was in restraints. Treatment team members reported that 1:1 supervision was not implemented because of an impending JCAHO site visit at CSH. When interviewed by DRVD, the Unit Psychiatrist said that the change to the plan did not really **require** 1:1 observation, but other members of the treatment team stated that the intent was **clearly** to require 1:1 observation of GH while she was in seclusion and restraints. The Forensic Unit Director stated that he was aware that the team had decided not to immediately implement this change in the IBP.

All treatment team members said that the primary therapist and the unit psychologist trained staff regarding implementation of the IBP, but many unit staff interviewed reported that they were never trained on the plan. One nurse reported that the plan was reviewed by the personnel on the ward during her shift, but that no formal training was given by the professional staff.

The prolonged use of seclusion and restraints effectively terminated GH's participation in group therapy activities. The CSH record reflects that her physical problems continued. On April 26, 1996, it was noted that she "passed out in bathroom after smoking." The record notes that on May 17, 1996, she was dizzy and short of breath with vomiting. Vomiting was also reported on May 23 and May 27, 1996. It was noted in the record that her father died in May 1996.

GH's last psychiatric update on May 18, 1996 identified a change of diagnoses to: Axis I, Schizoaffective Disorder; Axis II, Borderline Personality Disorder (with antisocial traits); and Axis III, HIV+.

D. The Events of June 4 to June 29, 1996

Throughout June of 1996, the record reflects that GH complained of difficulty breathing and was given inhalers for asthma. On June 4, 1996, the notes state that GH "claims she passed out." The physician noted his impression that this was manipulative behavior to obtain an order for bed rest. GH also reported dizziness and "feeling bad" on June 5, 1996.

An annual physical examination by CSH on June 12, 1996 noted "several papular rashes on trunk" and extremities. Her pulse rate was elevated at 90 and her respiratory rate was elevated at 22. On June 23 and June 26, 1996, GH again reported dizziness and "feeling bad." The physician's chart notes on June 26, 1996 indicate that GH:

> Still complains of feeling weak. Patient is alert, not in any distress BP 132/80 Physical finding: no acute medical problem identified. Case discussed with her primary therapist before. Due to H/O HIV and asthma and chronic bronchitis will allow bedrest prn.

Laboratory tests performed at HDMC on June 27, 1996 indicated that GH was suffering from hypokalemia (low potassium), low platelet count, and low carbon dioxide levels. The report is initialed by the Forensic Unit primary care physician but the date of his review was not noted. An EKG at HDMC on June 27, 1996, also indicated a sinus tachycardia of 130 beats per minute. The Forensic Unit primary care physician stated that this report was not received by the Forensic Unit staff until July 1, 1996.

On June 28, 1996, the CSH physician's progress notes state that GH:

> Complains of not feeling well. Exam: Alert, no acute distress BP 110/80 T 975 Resp 20 P 96 Lungs clear Heart RSR Abdomen soft Skin: numerous self-abusive skin lesions Plan: Continue to observe and allow bedrest.

An order for bed rest as needed for 30 days was entered, with vital signs to be taken each shift. A note from the primary therapist on June 28, 1996, described GH as "clammy and perspiring profusely. Breathing rapid." The note also comments that "she has resumed acting out by vomiting in public places."

The following events of June 29, 1996 were determined by interviews with staff and patients and reference to chart entries. At approximately 10:45 a.m. on June 29, 1996, GH stated that she felt

bad. She refused to walk to the dining room, stating that she was having a fainting spell. She also complained of shortness of breath but smoked two cigarettes at her scheduled break. Sometime past noon, when the patients left the ward to walk to the cafeteria for lunch, GH dropped to the floor in the hall and refused to get up. When staff attempted to move her, she was uncooperative, began screaming and yelling, and urinated in her clothing. However, she was not threatening or assaultive towards staff or others. The crisis response team was called and she was physically carried back to Ward 7.

On the ward, GH continued to yell and scream. At approximately 1:00 p.m., the ward nurse and FMHT staff placed GH in 4-point restraints to the bed in a seclusion room two doors down from the nursing station. The door to the room was closed, and no direct observation was ordered or provided. Another patient was in the middle room with 1:1 observation. After she was placed in restraints, GH was given a "prn" injection of Ativan to reduce agitation but she continued yelling. GH was checked by a FMHT every 15 minutes, at 1:15 p.m. and 1:30 p.m. At 1:30 p.m., GH complained of difficulty breathing and was given 2 puffs on her Ventolin inhaler by the ward nurse. The ward nurse returned to the nursing station and, a few minutes later, noticed that GH had stopped yelling. She and a FMHT went to the seclusion room and observed GH through a small window in the closed door. GH was lying still. The ward nurse waited for a moment to see if there was any movement, then entered the room and found GH to be unresponsive. The ward nurse left the room and went to the nursing station to call for help on the radio.

The Building 39 Charge Nurse stated that she received the call for emergency assistance in her office, which was on the second floor at the other end of the Building 39. The Charge Nurse retrieved the emergency medical kit from the next room and ran downstairs to Ward 7, taking at least two to three minutes to get to the patient. She charted her arrival time as 1:37 p.m. The Charge Nurse found GH lying flat on the bed in four-point restraints. No emergency care had been initiated. The Charge Nurse initiated CPR, but determined that the bed did not offer a suitably rigid surface for good chest compression and had GH moved to the floor. CPR was resumed and continued until approximately 1:50 p.m., when GH was examined by

the medical officer on duty (MOD). The MOD noted that she had no pulse and her pupils were fixed and dilated. He pronounced GH dead at 1:55 p.m.

The CSH medical chart entries regarding the events of June 29, 1996, are set forth in Appendix B. Staff generally agreed that these entries were accurate as to the sequence of events, but did not necessarily reflect the precise times when events occurred.

Unit staff had contacted building security to request Emergency Medical Technician support and an ambulance to transport GH to an emergency room. When the security officer called "911" she was first placed on hold and then transferred to the police department at the Southside Virginia Training Center (SVTC), which abuts CSH. There was further delay when SVTC police requested a code word which was required in order to prevent unauthorized "911" calls; the code word had not been provided to the security officer. The SVTC police did contact "911" and request an ambulance, but the request was canceled when GH was pronounced dead.

The ward nurse on duty during this incident did not usually work on Ward 7 and was unfamiliar with GH's medical and behavioral history. Many of the staff stated that, due to her respiratory problems, GH was routinely placed on the bed with a spare mattress folded underneath her mattress in order to raise her head. However, there are no chart notes which document the use or necessity of this practice, and GH's head was not elevated on this occasion.

Staff also reported that GH was generally placed on 1:1 observation with the door open while in restraints, and that the doctors familiar with GH generally required direct observation. When questioned as to why GH was not on 1:1 observation on June 29, 1996, several staff responded that the order for restraints written on June 29, 1996, did not require it. The MOD who wrote that order was not routinely assigned to the Forensic Unit.

E. Report of Autopsy

The death certificate prepared by the treating psychiatrist listed the cause of death as "asthma–reactive airway disease". However, the

final autopsy report dated January 24, 1997, determined the cause of death to be "acute and chronic myocarditis while in restraints." The autopsy report states:

> Major pathologic changes were present in both the heart and lungs. Examination of her heart showed that it was enlarged at 570gms (with normal being approximately 300-350gms) and microscopic sections showed both an acute and chronic infection of the heart characterized by infiltration of both neutrophils and lymphocytes into the interstitial tissues of the heart. In multiple foci these lymphocytes were actively destroying heart muscle. An acute and chronic myocarditis is not an uncommon finding in HIV infected patients and can cause death through either direct damage to the heart muscle or by disrupting the normal electrical ribbons of the heart resulting in a cardiac arrythmia. The enlargement of the heart occurred secondary to the lung findings discussed below.

The autopsy report also noted pulmonary hypertension with cardiac hypertrophy (enlargement of the heart). Asthma as an acute process was not supported by the autopsy report. The autopsy found that:

> Microscopic examination of the lungs revealed changes in the vessels consisted (sic) with a diagnosis of pulmonary hypertension. The changes seen are characterized by an increase in the thickness of the vessel walls causing a narrowing of the vessel lumen and a resultant increase in the blood pressure necessary to push blood through the narrowed lumens. This increased pressure causes the heart to work harder and over time will result in both left and right ventricular hypertrophy as seen in this case. Additionally, the walls of many of the small to medium size vessels were infiltrated by chronic inflammatory infiltrate (vasculitis). A finding of vasculitis is often seen accompanying pulmonary

> hypertension. The finding of atherosclerotic plaque along the pulmonary arteries and at the lung hilum is also consistent with a diagnosis of pulmonary hypertension. In this case, the decedent experienced periodic shortness of breath which is a finding of pulmonary hypertension and is often confused with reactive airway disease (asthma).
>
> While pulmonary hypertension is a serious disease, the cause of death in this case is due to the extensive damage to the heart muscle by inflammatory infiltrate (myocarditis).

The report concluded that "there were no assault type injuries to suggest either a struggle, physical abuse, or asphyxia." There was also no evidence of any drug toxicity. There were additional findings of inflammatory infiltrate in the liver and lymph nodes, and chronic leptomeningitis in the brain. None of these findings were considered a cause of GH's sudden death.

F. Additional Staff Comments

Forensic Unit staff offered the following general comments regarding the treatment provided to GH:

The primary care physician commented that many of the referral forms and consultation reports from MCV and SRMC regarding GH were either not in the medical chart or were incomplete. There was no formal system to track referrals to ensure that appointments were kept or that completed reports were provided to the referring physician. He also noted that a page-long summary of his exam of GH on June 28, 1996, the day before her death, was missing from the chart.

Unit staff stated that inadequate staffing and excessive overtime were significant problems in the Forensic Unit. Staffing records indicated that between June 1 and June 26, 1996, FMHTs on the Forensic Unit worked 423 overtime shifts. In Ward 7, there were 395 shifts worked, of which 65 (16.5%) were worked by staff held over from the prior shift. In addition, 28.5% of the personnel working regular shifts on Ward 7 during this period were not routinely assigned to that ward.

The quality of patient interventions deteriorated as staff tired, and staff were often unaware that they would be required to work an overtime shift until at or near the end of their regular shift. One staff member observed that "staff had no support; we're understaffed and didn't have extra staff even when patient behaviors had escalated to the point that staff were totally burned out…(we) felt all alone with no volunteers to help." This theme was evident in the majority of staff interviews.

Review of training records indicated that staff were trained in the MANDT System for managing patient behavior. Many staff suggested that their effectiveness could be increased and morale and safety improved by regular de-briefings after responding to an "aggressive incident" or an emergency response. Staff reported that de-briefings do not occur due to lack of time and understaffing. Staff who responded to either the "aggressive incident" or the emergency call regarding GH on June 29, 1996, were not debriefed on those incidents, and some felt that a support group or counseling for staff on therapeutic interventions might help them deal with residual emotions.

Staff reported that the Forensic Unit provided inadequate space for therapeutic activities and interventions. When GH's behaviors escalated, there was no place where she could get away from other residents for quiet time in order to calm down. Patients are generally not allowed in their rooms during the day, leaving 25-30 patients and 5-6 staff to share space in the day room of Ward 7. The small room that serves as the ward nursing office adjoins the day room but has inadequate working space or furnishings for staff. GH's demonstrated difficulties with interpersonal relations were exacerbated in a ward with no privacy or personal space.

Staff and patients consistently identified the existence of only one women's ward in the Forensic Unit as a major problem. Female patients who met treatment goals were unable to move to a less restrictive environment as their behavior stabilized. There was no ability to physically separate residents for either safety or treatment reasons.

Most staff commented that their basic training was adequate. However, most felt that there was inadequate communication, lack of

emotional support, and a lack of staffing to serve individual clients who presented special difficulties or problems. Staff indicated that although CSH required one hour of annual training on infectious diseases, it was focused on general control of infectious diseases, including AIDS, rather than the particular problems experienced in working with clients such as GH.

Interviews of staff indicated a discrepancy in staff's understanding of the disease prevention requirements of working with GH. Senior staff clearly understood that gowns, gloves, and facial shields were required when working closely with an HIV+ patient. However, many of the other staff members questioned stated that masking and gowning were seldom done. According to these staff members, the wearing of protective equipment on the ward occurred only during very "hands-on" activities, such as bathing an HIV infected patient in restraints.

IV. Findings and Conclusions

Based upon this investigation, the Department for Rights of Virginians with Disabilities finds that GH died because of inadequate medical and mental health treatment at CSH. GH suffered from a progressive infection of the heart and lungs which was undiagnosed and untreated. She was subjected to an inhumane behavior management plan which lacked theoretical and clinical support. Her care was provided by staff who were overworked and clearly frustrated by the challenges her care presented. Services were delivered in an inadequate physical facility which hampered effective therapeutic interventions.

DRVD's medical expert concluded that:

> GH was suffering from complex, but understandable and treatable, mental and physical disorders. For the most part, her care at Central State Hospital, especially in the last year of her life, was fragmented, directionless, unscientific, and inhumane. The treating staff did not seem able to look beyond her objectionable behaviors to the basis of these behaviors. Despite opportunities to more fully understand the case, the overall treatment milieu disregarded the notion that GH had brain impairment in both her cognitive functioning and impulse

control. Efforts to address her behaviors with this theoretical framework were ignored; a punitive approach was taken….

I suspect staff members were afraid of GH's HIV infection. Her physical complaints were regarded as functional and not seen in light of her HIV infection. Given the state-of-the-art with regards to HIV infection, GH did not have to suffer with an advanced form of cardiomyopathy which, with the stress of restraints, caused her death. She could have been treated with antibiotics and considered for a trial of anti-retroviral medication….

The conclusion reached in this review of the clinical records is that the lack of vision and diagnostic treatment and planning by the treatment team at Central State Hospital contributed significantly to the death of GH.

DRVD's detailed findings are as follows:

A. The mental health treatment provided to GH by Central State Hospital did not reflect a systemic approach to diagnostic and treatment planning, and there was no documentation of the clinical or theoretical rationale for the treatment provided.

The CSH record contains no evidence that the treatment team approached the medical and mental health needs of GH in a comprehensive manner. There is no evidence of a systemic approach to diagnostic and treatment planning, and little documentation of the clinical or theoretical rationale for the treatment provided. GH's physical problems were not properly evaluated and were largely dismissed as behavioral issues. Recommended evaluations of organic brain function were not pursued. Despite testing and history which indicated poor impulse control, no diagnosis of Impulse Control Disorder or Intermittent Explosive Disorder was made. It is generally accepted that correct diagnosis is the key to appropriate treatment. However, in this case, diagnostic information was either not carried forward or was disregarded by the treatment team.

GH carried a diagnosis of mild mental retardation upon admission to CSH in 1992. The evaluation done by the ILPPP staff in 1995

described her intelligence as "at the borderline of being mentally retarded." The psychological evaluation done for the court in March 1996, states that "[g]iven the standard error of measurement and Ms. H's poor social adjustment, a diagnosis of Mild Mental Retardation is appropriate." Despite this documentation, there is no indication that this cognitive impairment was considered in any of the treatment team's diagnostic work-ups or in the development of a Treatment Plan or Individual Behavior Plan.

In July 1995, the treating psychiatrist in Building 96 recommended a PET scan and further evaluation of GH for organic brain abnormality. In November 1995, the ILPPP evaluation indicated that GH "is most likely suffering from a brain abnormality which manifests itself in seizures and atonic episodes and which contributes to her emotional and behavioral outbursts," and recommended an MRI of the brain or additional specialized EEG's as possible diagnostic tools. The ILPPP further stated that "…the clinical record is very much at variance with itself and in places quite wanting. To offer a definitive diagnosis with the available information might be misleading."

The Temporary Custody Evaluation in March 1996 strongly suggested that there was no clinical indication of psychotic process and that "Schizoaffective Disorder" was not the correct diagnosis. The recommended diagnosis was "Borderline Personality Disorder" and extensive treatment recommendations were offered. In May 1996, the treatment team added a diagnosis of Borderline Personality but did not remove the diagnosis of Schizoaffective Disorder. There is no explanation for this decision and none of the treatment recommendations were addressed.

DRVD's medical expert concluded:

> The treatment milieu was untherapeutic for GH. It is difficult to believe that despite the quality of consultation from the Institute on Law, Psychiatry & Public Policy at the University of Virginia, no recommendations were followed. No attempt to adopt or to even address the findings of the evaluation was documented in the clinical record. The behavior of the clinical team, as evidenced

> from the documentation provided for review, had only one end-point: the death of GH. Opportunities to correct this were missed, and the leadership of the hospital appeared not to take seriously the clinical issues surrounding the case of GH….
>
> Despite a clear history of impulsivity and seizure-like phenomena, and the absence of supporting data for a psychotic disorder, GH continued to retain a diagnosis of record of Schizoaffective Disorder. The labeling of her in this category de-focused the efforts of the treatment team and attributed certain behaviors to this syndrome rather than to another more plausible one. Should the team have understood why GH was acting the way she had been, she would have received proper treatment and would not have died in restraints.

GH had a documented history of seizures and/or pseudo-seizures and there was much discussion of this problem earlier in her hospital stay. However, after her transfer to the Forensic Unit, little serious medical attention was given to this issue. Despite clear recommendations from the independent evaluators at ILPPP in November 1995, neurological testing was not pursued for GH.

B. Central State Hospital failed to adequately evaluate and treat GH's physical complaints related to progressive cardio-pulmonary disease.

A diagnosis of pulmonary hypertension was initially made by the MCV Infectious Disease Clinic on December 2, 1993, and cardiopulmonary issues were subsequently raised by the following evaluations:

- 2/24/94, MCV Pulmonary Clinic (possible pulmonary hypertension)
- 3/17/94, MCV Pulmonary Clinic (pulmonary HTN, recommend pulmonary function test)

- 3/25/95, SRMC (possible cardiovascular and pulmonary peculiarities)
- 7/13/95, SRMC (complaint of seizure, abnormal EKG)
- 8/31/95, MCV Infectious Disease Clinic (pulmonary arterial hypertension or conceivably a left to right shunt)
- 10/29/95, SRMC (question pulmonary arterial hypertension)
- 3/30/96, SRMC (suspicious for congenital heart defect with superimposed pulmonary arterial hypertension)

Significantly, the CSH record contained no report or information from any of these consultations. There is no indication that recommended tests were performed or that GH was referred for a cardiology consult. A diagnosis of pulmonary hypertension was not considered as a factor in treatment decision making for this patient.

There was no attempt to reconcile the conflict between radiology reports from MCV and SRMC and reports provided by Hiram Davis Medical Center. The HDMC radiology report on September 7, 1995 indicated "…no remarkable cardiomediastinal finding. The lungs are clear and no pleural abnormality is defined. Bony structures are unremarkable." In contrast, the SRMC found on October 29, 1995, that:

> There is prominence of both hila, as well as the main pulmonary artery segment. Slight interstitial prominence is present throughout both lungs."… "Questionable early infiltrate, right lung base. Prominent hila and main pulmonary artery segment. Question pulmonary arterial hypertension. ? Does this patient have sarcoidosis. Computed tomography could be performed for complete evaluation of the hilar regions to exclude adenopathy.

The numerous observations in the CSH record that GH "fell out" or slumped to the floor unexpectedly and frequently experienced difficulties after smoking were ignored. Although both inadequate heart function and inadequate lung capacity can result in falls, there is no evidence in the CSH record that medical personnel explored potential physiological causes for these episodes.

Despite GH's repeated complaints of shortness of breath, chest pain, dizziness, and fainting, and her documented cardio-pulmonary problems, the treatment team proceeded to implement a physically stressful, restrictive behavior management program., In the last week of her life, GH's health problems were viewed by CSH staff as attention seeking behaviors.

DRVD's medical expert concluded that:

> From a medical standpoint, GH's care was less than adequate. While complaining several times of physical distress, her somatic complaints were not fully evaluated or even taken seriously. Evidence existed which indicated that Ms. H had cardiac pathology (abnormal electrical activity), yet this was not addressed as a clinical issue by the treatment team. It should have been a clear contraindication in the prescription of any restrictive technique such as restraints. A cardiology consultation should have been conducted which would have elaborated the cause of Ms. H's breathing difficulty as clearly related to right-sided heart failure. Additionally the myositis in her cardiac muscle would have been discovered. This latter disease process was untreated despite numerous complaints by the patient of feeling weak, dizzy, and passing out on several occasions. Ms. H was not properly medically evaluated or treated.
>
> Additionally, hypokalemia, which can cause abnormal electrical conduction in the heart, was noted just days before her death. This should have prompted an immediate medical evaluation.

The autopsy report noted that pulmonary hypertension "is a serious disease" which "causes the heart to work harder and over time will result in both left and right ventricular hypertrophy." At the time of her death, GH's heart was more than 50% larger than normal.

C. The Individual Behavior Plan developed in April 1996 lacked clinical support and subjected GH to conditions so restrictive as to constitute inhumane treatment.

Prior to April of 1996, seclusion and restraint had been used by CSH as a behavior management tool for GH. Staff reported some success with the previous IBP using restraints for a minimum of 10 hours. The treatment team's data also indicated that the average time required for GH to calm down was 6.8 hours. Despite this data, the team developed a plan which utilized at least 56 hours in restraints; a minimum of 48 hours in four- or five-point restraints, four hours in ambulatory restraints, and four hours in wrist restraints. The 48 hour minimum time in four- or five-point restraints was arbitrarily chosen; no member of the treatment team interviewed could identify any professional references, peer review literature, or clinical studies which supported the imposition of such restrictive conditions.

DRVD's medical expert stated:

> There was no clinical evidence to support the institution of a seclusion and restraint policy so restrictive and so depriving. In an individual who was cognitively impaired and suffered from an organic brain disorder, the use of such long-term, restrictive, and depriving modalities was bound to fail. The intent of the seclusion and restraint program appears to have been punishment; there was no scientific basis for this approach. There was neither a sound psychological explanation for this treatment regimen. Pharmacologic options were not widely supported by the staff, and therefore, no extended trial yielded adequate results. Clonidine, propranolol, or aniticonvulsant combinations were not tried.

In his July 11, 1995 memo, the treating psychiatrist in Building 96 worried that burned-out staff "believed that this patient was treated too well....They wanted more discipline (or perhaps punishment?) hallowed by a Behavioral Treatment Plan." Once the IBP was

implemented in April, 1996, staff increasingly relied upon seclusion and restraint as a response to GH's undesirable behaviors, and the use of four- or five-point restraints to bed increased dramatically. (See Appendix C).

In practice, the IBP was clearly punitive in its approach to GH's behaviors. On June 29, 1996, GH was not exhibiting assaultive or self-mutilative behaviors. She had complained of physical problems and weakness for several days, and there was a physician's order to allow her bed rest as needed. Nevertheless, when she dropped to the floor, it was regarded as a behavioral problem requiring physical intervention by staff. There was also an order for Ativan as needed for agitation, but this was not administered to GH until after she had been placed in restraints. There was no evidence that staff considered any less restrictive alternatives in responding to her behavior on this date. Staff also failed to provide 1:1 observation as required by the approved IBP.

GH spent one-third of the last two months of her life in restraints. Between April 29 and June 29, 1996, she was in four- or five-point restraints to bed for 485 hours, and she was in ambulatory restraints for an additional 73 hours. (See Appendix D).

D. CSH failed to properly administer Cardiopulmonary Resuscitation (CPR) to GH on June 29, 1996, and failed to provide GH with advanced cardiac life support (ACLS).

CPR was not begun immediately upon discovering that GH was unresponsive and had no detectable pulse. A delay of at least three to five minutes occurred while the unit nurse notified the charge nurse and awaited her arrival. By recognized standards, the unit nurse should have immediately initiated CPR while other staff called for emergency medical support and additional assistance. This did not happen." The only alternative to effective CPR for the cardiac arrest victim is death."

CPR was prematurely terminated in this instance. The MOD pronounced GH dead five minutes after his arrival, and after no more that 15 minutes of CPR. CPR was discontinued and no ACLS was provided to GH. This does not comply with the standards and

guidelines of the American Medical Association or the International Liaison Committee of Resuscitation. Specifically, the attending physician should have observed GH for cardiovascular unresponsiveness for 15 to 30 minutes prior to discontinuing CPR, and only after advanced cardiac life support was provided.

As a Level IV emergency facility, CHS does provide advanced cardiac life support (ACLS), monitor cardiac function, perform EKGs, utilize defibrillators, or administer routine emergency cardiac drugs. Central State Hospital Instruction #5215.1F, dated May 16, 1996, provided that "individuals experiencing medical emergencies…shall be transported to the nearest health care facility capable of meeting their needs." CSH failed to follow this instruction on June 29, 1996.

Efforts to summon emergency rescue personnel to provide ACLS and transport GH to an emergency care facility failed. Hospital procedures for contacting "911" were not adequate and the rescue squad was required to re-contact the hospital and verify the request for emergency services. This delayed their response and the request for an ambulance was subsequently canceled prior to its arrival.

E. Poor medical records management failed to make relevant diagnostic and treatment information readily available to the treatment team.

CSH relied upon MCV and SRMC to provide specialty care to GH. However, most of the referrals to MCV and SRMC were not documented in the CSH records, and no referral forms or consultation reports were available to the treating CSH staff. There was no formal system in place to track referrals to ensure that patients were seen and that reports were provided to CSH by the referral facilities.

Critical information was not communicated between the Building 96 staff and the Forensic Unit staff upon GH's transfer in August 1995. The July 11, 1995 memorandum from the Building 96 treating psychiatrist, which summarized his treatment concerns for GH, was not provided to the Forensic Unit treatment team. The CSH Medical Director stated that this memo was not made part of GH's medical record because it addressed "personnel and staffing concerns."

As already noted, comprehensive evaluations of GH conducted pursuant to legal proceedings were not maintained in the patient's clinical record. The November 1995 ILPPP evaluation was not reviewed by the treatment team. Although this report and its recommendations were known to GH's treating psychiatrist, this diagnostic information was not shared with other members of the treatment team or with the Forensic Unit primary care physician. It is unreasonable to expect clinicians to make appropriate decisions without access to all available data and information.

F. CSH staff failed to follow CSH policy regarding the transfer of GH to the Forensic Unit on August 10, 1995.

In August 1995, no transfer summary was prepared by CSH staff regarding the transfer of GH from Building 96 to the Forensic Unit. CSH Hospital Instruction 5160.4B, "Civil Commitments to the Forensic Unit," required that the sending program director contact the Forensic Unit director and patient advocate to discuss any possible transfer of a civil patient to the forensic unit prior to asking the clinical director and hospital director for approval of the transfer. The policy required that this request:

> should be accompanied by a written assessment reflecting background data and the rationale supporting the need for transfer. Obvious emergency situations may be presented to the Hospital Director by telephone with the expectation that a written follow-up statement will follow….
>
> The treatment team of the sending unit should prepare an updated, complete psychiatric evaluation including all appropriate aspects (i.e. mental status, physical, social, etc.) within a period of 24 hours….The sending treatment team will follow the patient in the Forensic Unit with Forensic staff assuming the day-to-day responsibility for management and the facilitation of the treatment plan.…The Primary Therapist of the sending unit will have at least bi-weekly

contact with the patient and unit staff, and make weekly documentation in the medical record.

Based on the chart notes and interviews, it is apparent that none of the professionals involved in GH's care complied with hospital policy or otherwise shared information on this patient.

G. Staffing on the Forensic Unit was inadequate and resulted in heavy utilization of overtime personnel and "staff burnout."

Staffing of the Forensic Unit was a significant concern. Difficulty in keeping adequate numbers of trained forensic mental health technicians (FMHTs) available in the Forensic Unit required the extensive use of personnel working double shifts. The heavy use of staff from other wards meant that direct caregivers were often unfamiliar with the patients. This was particularly problematic in a high acuity unit such as Ward 7.

"Staff burnout' was an issue raised by all clinical staff interviewed. Forensic Unit staff members indicated a deterioration in performance during overtime shifts, and a decreased ability to respond to GH in an effective therapeutic manner. Staff cannot provide a therapeutic environment and meet patient needs without adequate time off for rest and to meet their personal needs.

H. The Forensic Unit provided inadequate space for appropriate therapeutic activities and interventions.

According to CSH staff interviewed, the Forensic Unit physical plant was inadequate. Space for therapeutic activities and treatment was limited It was not possible to separate patients who were distraught or who exacerbated the behavior of other patients. Many staff members commented that when one patient escalated and demanded attention, others on the ward would do the same. Options for voluntary time-out for patients were limited due to lack of space and privacy. Staff believed that the ability to work with individual patients away from the crowd would have improved the quality of interventions.

All female patients in the Forensic Unit were confined to a single ward, regardless of their level of functioning. These patients were unable to transfer to a less restrictive environment as treatment goals were attained.

V. Recommendations

It is recognized that Central State Hospital has been reviewed by JCAHO and the United States Department of Justice since the death of GH. DRVD's recommendations acknowledge efforts undertaken by the CSH administration to remedy the problems identified by these agencies. However, many of the problems are on-going and will require the continued devotion of time and resources to effect needed changes.

1. Seclusion and restraints should be used only in crisis situations to protect the patient from harming himself or others.

Central State Hospital Policy #NS-5, "Seclusion or Restraint, Emergency," effective March 17, 1998, provides:

> It is the policy of Central State to use Seclusion or Restraint to the least extent possible, consistent with patient and staff safety. Seclusion or restraints represent the most restrictive techniques and are discouraged as a routine practice. These techniques must only be used as crises management tools. In all cases, the least restrictive alternative will be used. ...The use of restraint or seclusion will require clinical justification and will be employed only to prevent a patient from injuring himself or others, or to prevent seriously disrupting (sic) of the therapeutic environment. Restraint or seclusion will not be employed for the convenience of staff or to reduce the need for staff.

CSH Orders for five-point restraints are limited to 2 hours, with a required nursing assessment at the end of the first hour. Patients are on 1:1 observation at all times. After 2 hours, the physician must perform an evaluation of the patient before any new order may be written. The use of restraints may continue for as long as necessary,

based upon the physicians assessment of the patient's current clinical status.

2. **All direct care staff should be trained to provide emergency services in accordance with the Standards and Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care of the American Medical Association.**

   CSH policy regarding the administration of CPR to patients should comply with recognized standards and guidelines. Staff should be fully trained regarding the facility's expected response to medical emergencies and the requirement that CPR be initiated immediately and continued through transport to the emergency room. CSH Hospital Instruction 5215.1G dated September 16, 1997, states:

   > Central State Hospital operates a Level IV emergency service. Consequently, individuals experiencing medical emergencies on the campus shall be promptly transported by ambulance to the nearest health care facility capable of meeting their medical needs. Campus medical personnel will determine the existence of a medical emergency and render sufficient lifesaving measures to maintain the individual until the arrival of emergency transportation. CPR will begin if there is an apparent cardiac and/or respiratory arrest according to CPR training guidelines. …CPR will be continued and the patient will be transported by ambulance to the emergency room. Once CPR has begun, it will be continued through transport to the emergency room.

3. **Procedures for requesting emergency medical assistance should be revised to ensure that hospital personnel have the ability to summon emergency assistance without confusion or delay.**

4. **Medical records management must be better integrated to ensure that all clinical evaluations and patient data are accessible to the treatment team.**

A. CSH should implemented a formal system to track patient follow-up to medical appointments and consultations, and to ensure that consultation reports are received by CSH and available to the treating physician in a timely manner.

B. A summary sheet showing all of a patient's medical data and any special precautions should be readily available in the record. The continuing rotation of staff and use of temporary contract providers make it critical that a care provider be able to quickly identify critical medical and psychiatric information "at a glance" in an emergency.

C. Documents maintained in the legal section of the patient's record which contain medical or mental health evaluations, diagnoses and treatment recommendations should be readily available to the treatment team.

CSH has advised that the "legal section" of the patient record is now integrated into the medical chart, including evaluations and court orders. The only exception is pretrial evaluations to determine competency at the time of the offense, which are protected by court order and available only to the patient's defense counsel.

5. The treatment team process should utilize a systemic approach to diagnostic and treatment planning which addresses the medical and mental health needs of patients in a comprehensive manner. Treatment planning should be directly related to discharge planning.

Central State Hospital Instruction No. 5300.4, "Treatment Planning," effective January 1, 1998, includes both forms and processes for treatment planning, treatment plan review, and clinical assessments which should enhance comprehensive treatment planning and documentation. This treatment planning process is greatly different from past practices and will require thorough training for all personnel. Successful implementation will also require regular record audits to ensure that the new process is thoroughly understood and consistently implemented by all members of the clinical staff at CSH.

6. **Direct care staff should receive additional training in the use of non-physical interventions with clients.**

Although all staff are currently trained in MANDT procedures, it is apparent that not all staff understand the philosophy and concepts upon which MANDT is based. Additional training beyond MANDT regarding the management of specific clients should be available to unit staff.

7. **Unit crisis response team members should be trained as a team and be de-briefed following every aggressive incident requiring physical intervention.**

Central State Hospital Instruction 1510.7, "Mandt Leadership," effective 2/16/96, requires that the RN in charge of managing an aggressive incident "debrief" staff after the incident. If crisis teams are to be used, they should be trained to work as a team and be de-briefed after each intervention. Good performance and effective patient interventions should be recognized and less effective responses identified at the earliest opportunity. Recommendations to improve the effectiveness of future interventions should be documented in the patient's record.

8. **Overtime policies should be revised to limit double shifts by direct care and clinical staff, except as necessitated by unexpected illness and emergencies. CSH must continue its efforts to recruit and retain permanent staff and to reduce its reliance on temporary and contract personnel.**

CSH reports that the current use of overtime staff in the Forensic Unit is practically non-existent due to increased staffing and reduced patient census.

A lack of stability in the Forensic Unit professional staff continues. Staffing in the Building 39 Forensic Unit is currently 7 psychiatrists, 6 psychologists, 2 primary care physicians, and 1 nurse practitioner. Of these, only 2 psychiatrists, 1 psychologist, and 1 primary care physician have been on staff for more than one year. CSH reports that 6 new physicians have been recruited, including a new Forensic Unit Medical Director.

9. The Forensic Unit requires additional space for therapeutic activities and for staff offices and treatment rooms. Nursing stations must have adequate space for medication preparation, patient records, and must provide hand washing facilities.

Renovation of the existing Forensics Building, Building 39, and the addition of a new section began in 1997 and is ongoing. The new construction is expected to provide additional staff office space, as well as a group treatment room and individual patient interview room on each ward.

10. An additional ward for female patients should be available to the Forensic Unit to enhance classification and treatment of patients by level of functioning.

Currently, the Forensic Unit in Building 39 has one ward with only female patients, and one ward which has both male and female patients. CSH reports that it plans to expand the integration of male and female patients to a minimum of four wards.

In March 1998, CSH opened Forensic West, a medium security step-down unit, in Building 96. Forensic West has one male-only ward and one ward which integrates men and women; there is no female-only ward. This limits the step-down unit's availability to some female patients. Also, transfer from the Forensic Unit in Building 39 to Forensic West requires the approval of the Forensic Review Panel of a reduction in the patient's security level.

11. CSH staff should receive additional training regarding the use of universal precautions against infectious diseases and the management of patients with HIV infection.

Respectfully Submitted,

Dated: June 17, 1998 _____

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